Community Planning and Monitoring of Health Services -Karnataka Experience

2009

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Preface

This short report attempts to document some of the key processes and activities during the pilot phase of community based planning & monitoring of health services in Karnataka. A sound beginning has been made to this challenging, complex and exciting process. In the pilot areas, steps have been taken to restore people's confidence in the public health system and small but significant improvements have appeared.

Needless to say that the very purpose of the programme would not have been achieved without VHSC members whose enthusiasm, ownership and efforts helped realize the vision of improving health services. Perhaps the most significant are the efforts devoted by countless ordinary community members, who among other things participated in meetings and trainings, offered various forms of information, helped fill report cards, attended public events - thus ensuring that entire monitoring activity was genuinely and truly 'community based' and making this report possible.

We greatly acknowledge the initiative taken by the Ministry of Health and Family Welfare under its flagship programme, the National Rural Health Mission, to institutionalize community monitoring of health services in 9 states across India. We also acknowledge the Advisory Group on Community Action (AGCA) for designing and guiding the whole initiative at national level. Karnataka has been fortunate to have two member representatives at AGCA including Dr. H Sudarshan and Dr. Thelma Narayan who provided much needed enthusiasm, and initiated and guided the implementation of CPMHS in Karnataka state.

We thank Population Foundation of India and the Centre for Health and Social Justice, two key organizations who served as the national secretariat and provided technical assistance and coordination to the states.

We are obliged to the Dept. of Health and Family Welfare, Government of Karnataka, in particular the Principal Secretary, Health and Family Welfare and the Mission Director, NRHM for taking keen interest and extending cooperation

for smooth implementation of CPMHS in the state. We thank the State Mentoring Monitoring Group which under the chairmanship of the Mission Director, NRHM, included members from State Dept. of Health and Family Welfare as well as from civil society organizations who have been involved in community development processes for initiating, facilitating and overseeing the implementation of CPMHS in Karnataka.

Piloting of the CPMHS in Karnataka would not have became possible without the credible and experienced NGOs that took leadership and charge at state, district and sub district levels. We humbly appreciate the efforts made by state, district and Taluka level nodal NGOs as well as other NGO partners who helped in various capacities to facilitate the CPMHS processes in Karnataka. We are thankful to the health staff and Panchayati Raj members who extended their cooperation in the pilot districts.

We are very much thankful to Dr. Rajni Ved, member of the national review team, who reviewed the CPMHS in Karnataka and provided insightful observations and feedback.

CONTENTS

Abbreviations

AGCA	Advisory Group on Community Action
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CBO	Community Based Organisation
CHC	Community Health Centre
CPMHS	Community Planning and Monitoring of Health Services
CRP	Community Resource Person
CSO	Civil Society Organisation
ICDS	Integrated Child Development Services
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MO	Medical Officer
MPW	Multi Purpose Worker
NGO	Non Government Organisation
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PRA	Participatory Rural Appraisal
PRI	Panchayat Raj Institutions
SMMG	State Mentoring Monitoring Group
TOT	Training of Trainers
VHSC	Village Health and Sanitation Committee

Executive Summary

In 2005 Government of India launched the National Rural Health Mission (NRHM) with the vision to improve the status of the health and health services in rural India. In order to ensure that the services reach to those for whom they are meant the NRHM proposed Community-based Monitoring as one of its key strategies which was initially planned to be piloted in 8 Indian states by early 2007. Later on, Karnataka was included as the ninth state where the processes began in July 2007 and the actual implementation started by April 2008.

Overall framework of community monitoring under NRHM included establishments of Mentoring groups from state level down to block level and formulating planning and monitoring committees at various levels from village up to the state level. In Karnataka, 4 Pilot districts were selected with a target to cover 45 villages in each district. Despite the late inclusion, 562 Village Health and Sanitation Committees (VHSC) have been formed in four districts covering four Primary Health Centers (PHCs) per Taluka, against the original target of 180 villages in three PHCs per Taluka.

Karnataka chose to make two significant deviations from the national design. One was to expand the process to "planning and monitoring" from just "monitoring". Thus the initiative in Karnataka is referred to as Community Planning and Monitoring of Health Systems (CPHMS). The second was in terms of geographic coverage. The departure from national guidelines of covering five villages in each PHC area to attempt universal coverage of all villages in the PHC area has resulted in 80% to 100% coverage of villages under each PHC.

The state government took strong ownership of the programme and worked in close partnership with civil society organisations. State mentoring and monitoring group (SMMG) included key officers from the state health department and the non- governmental organizations that shared a common vision and commitment. SMMG has facilitated coordination at state and district levels and significantly influenced outcomes.The availability of committed NGOs who served as state, district and taluka level nodal organizations along with other NGO partners strengthened the quality of community processes and the pace of scaling up.

Key outputs in all PHC areas include: formation of VHSC, development of

village action plans, filling up of score cards and facility cards, and organizing Jan Samavad at PHC level in 36 of the total of 49 PHCs. 12 Taluka and 4 District Samavads have also been organized. Taluka and District committees could not be formed in want of relevant Government Order. As a result the existing committees at PHC and taluk level were trained on the community monitoring process.

Kalajatha as a prelude/precursor to VHSC formation served to mobilize communities and facilitated acceptance of marginalized groups by general community. Another initiative that resulted in high community acceptance of the process was a series of meetings held with different caste groups prior to the VHSC training.

Appointing ten community resource persons (CRP) at Taluka level to create VHSC, was a critical measure in achieving scale with quality. The CRP invested substantial time in working with all sections of the community in these areas where casteism is high to ensure appropriate representation on VHSC. A common focus across districts on the high level of investment in village processes including - three member CRP team to (i) mobilize community, (ii) form VHSC, (iii) train VHSC members and (iv) facilitate score card filling, have resulted in strong VHSCs.

Several variations from national guidelines in capacity building processes, strengthened the process-

- district level TOT for nodal NGO rather than one common state level TOT,
- high level of the on the job mentoring and support by district NGOs to Taluka NGOs,
- Use of PRA as the method of choice for VHSC formation and developing village action plans
- VHSC manual provided to every member of VHSC.

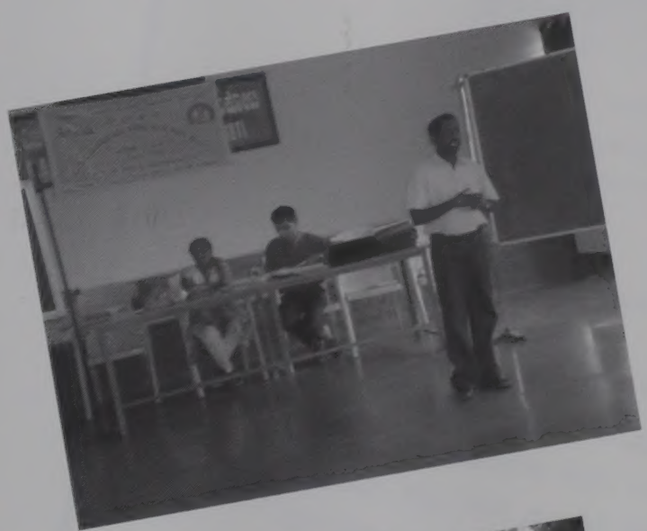
However, there were significant challenges faced on the time and human resources front. This was a key constraint for better supervision of documentation, review of village action plans, and ensuring VHSC score card quality.

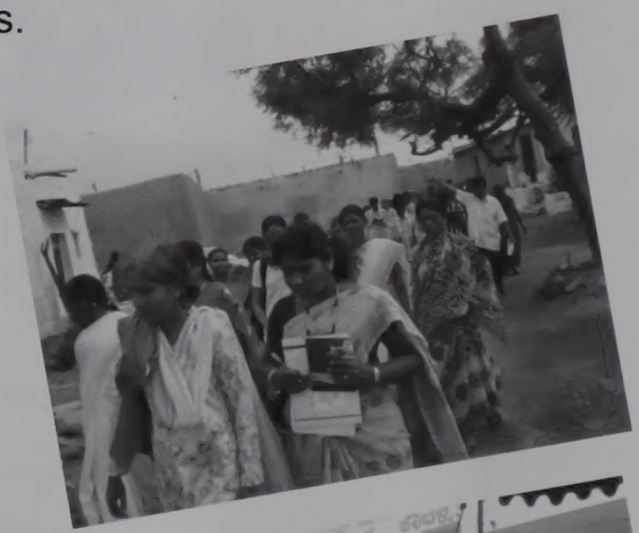
Given the absence of AHSA in some of the project areas, the convergence between health and ICDS was further strengthened at the village level, because of the Anganwadi Worker (AWW) taking on a leadership role as a co-convener, and in many instances serving as the de facto convener. However, despite the

engagement of PRI members as part of VHSCs, the state level leadership is yet to be fully translated at district, Taluka and PHC level both in PRI and public health system.

The score card was found complex to fill and utility was not clear to a significant proportion of VHSC members. All the districts were able to generate 3 rounds of score cards over the period of around 6 month. Analysis of the score cards shows the perceptions of community members on various health and health service parameters. It makes evident the poor status of quality of care and utilization of untied fund while child health fares comparatively better. On the whole, over the project period, all the parameters show differential degree of progress (RED signs decreasing while an increase in Yellow and Green signs). Jan Samvads have resulted in action being taken in some areas - such as use of untied funds at PHC and SC level for repairs and equipment or posting of health personnel in some cases.

Given the closure of the project, the present pace and depth of coverage is unsustainable unless adequate human resources and commensurate financial support are provided for. However, NGOs involved so far are committed to support and supervise the village processes for some time. State government is committed to expand these processes and has already planned for state wide strengthening of VHSCs on similar lines.





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(NRHM)

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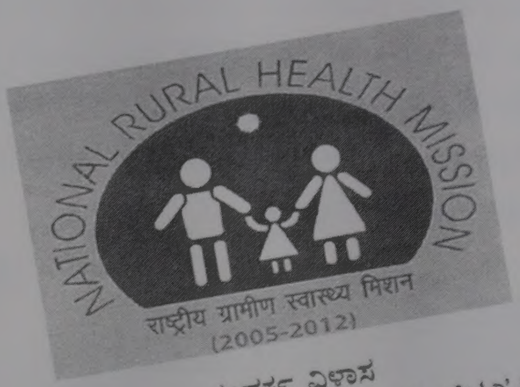

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Community Monitoring within NRHM

The Government of India launched the National Rural Health Mission (NRHM) on the 12th of April 2005.The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

Some of the goals of the Mission are:

- Reduction in child and maternal mortality
- Universal access to public health care services along with public services for food and nutrition, sanitation and hygiene
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.

Some of the Core Strategies through which the mission seeks to achieve its goals are:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through ASHA.
- Health Plan for each village through Village Health Committee
- Strengthening existing sub-centre, PHCs and CHCs
- Preparation and Implementation of an inter-sectoral District Health Plan
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.

In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability framework that includes Community-based Monitoring as one of its key strategies.

The accountability framework proposed in the NRHM is a three-pronged

process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at PHC, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the center of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

NRHM launched this initiative of community monitoring of health services in 8 states of the country in 2006. Karnataka was included later as the ninth state.

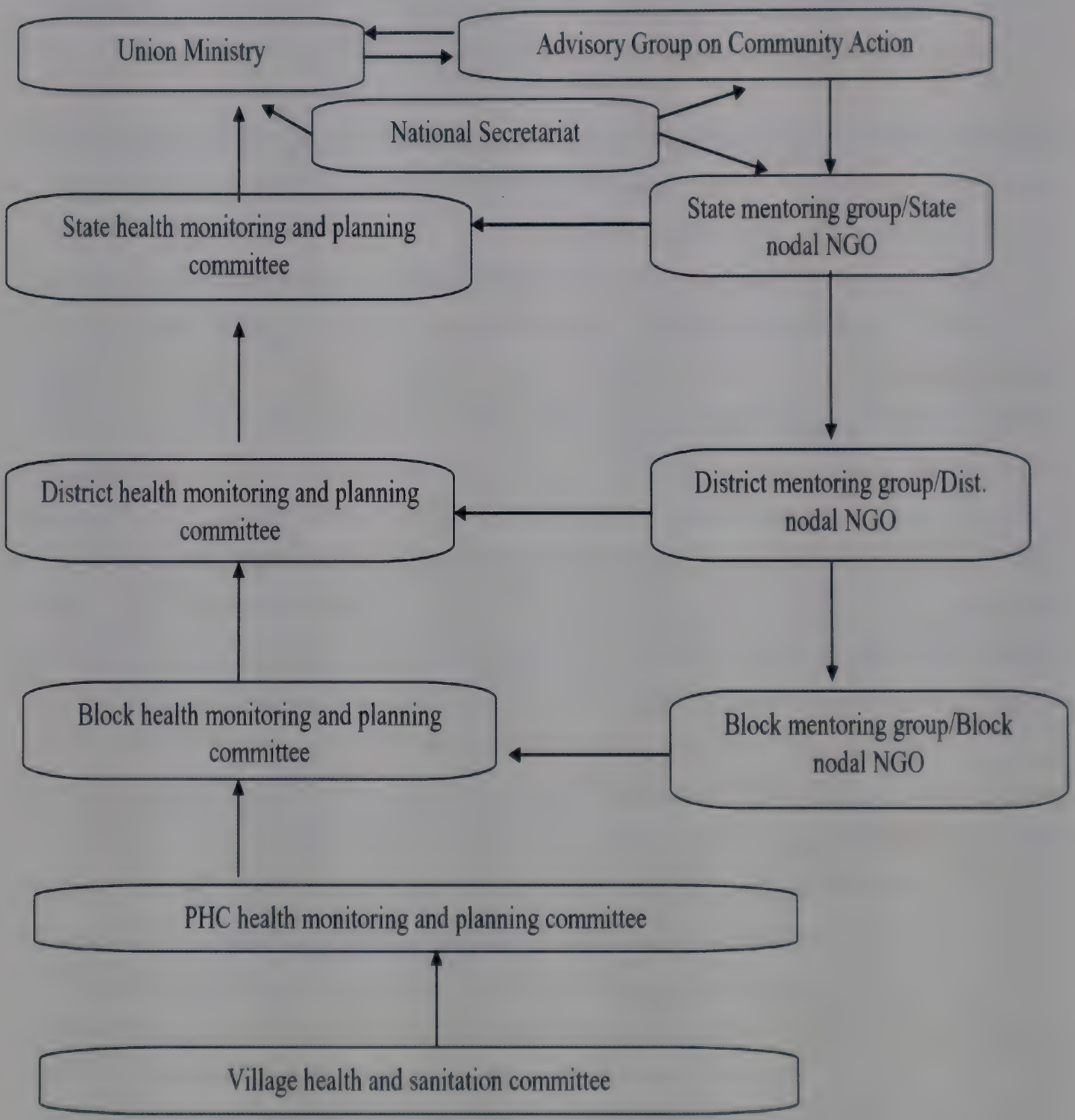
The exercise of "Community monitoring" involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives, to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organizations will monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

It was designed in a way that promotes the involvement of civil society. Unlike previous health programmes, the government has clearly defined the roles of Non Governmental Organization (NGOs) in the Mission. NGOs are not only included in institutional arrangements at National, State and District Levels but also they are playing an important role in facilitating the implementation of this initiative.

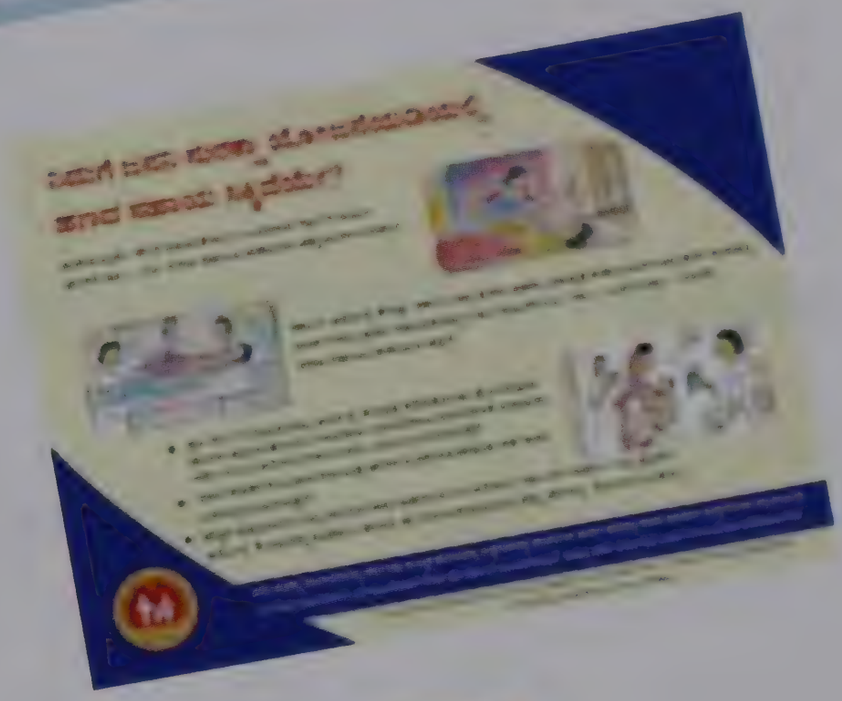
At the National level, an Advisory Group on Community Action (AGCA) has been formed to facilitate and oversee the planning and implementation of CPMHS. The Population Foundation of India (PFI), and the Centre for Health and Social

Justice (CHSJ) served as the national secretariat. The Figure: 1 depicts the organizational structure of Community Planning and Monitoring as envisaged under NRHM

Figure: 1 Framework of Community Planning and Monitoring under NRHM



Community Planning and Monitoring in Karnataka Background and processes



2.1 Background

The process of Community Monitoring under NRHM was launched in eight states in 2006 which did not include Karnataka. Karnataka was included later as the ninth state. Two of the national level AGCA members (Dr. H. Sudarshan and Dr. Thelma Narayan) were from Karnataka and felt that the timing and circumstances (strong civil society and high political commitment) were opportune to launch Community Monitoring in the state, despite the fact that is not a NRHM focus state.

Karnataka has been the focus of several innovations related to "communitization", in public health and other social sectors. Key among these are the Jana Aarogya Andolana Karnataka (JAAK: the state level chapter of the Jana Swasthya Abhiyaan or the People's Health Movement), past initiatives supported by the government and UNICEF for community monitoring, as part of the Border District Cluster Fund, and on the whole, a positive environment for civil society activism. Karnataka also has a history of partnerships with the NGO sector in managing public health facilities. NGOs managing these centers have, in turn instituted processes to improve governance and accountability. However this is the first time that there is an initiative to institutionalize community monitoring of health services in the state with stronger government support and commitment.

Karnataka ranks among the better performing states of the country. However the state includes four of the 100 most backward districts in the country. Table 1 to 3 provide a brief health profile of the Karnataka state.

Planning Commission's list of 100 backward districts for RSVY programme available on http://www.empowerpoor.com/backgrounder.asp?report=20 accessed on 1st Jan'09)

Table: 1 Demographic, Socio-economic and Health profile of Karnataka State as compared to India figures

S. No.	Item	Karnataka	India
1	Total population (Census 2001) (in millions)	52.85	1028.61
2	Decadal Growth (Census 2001) (%)	17.51	21.54
3	Crude Birth Rate (SRS 2007)	19.9	23.1
4	Crude Death Rate (SRS 2007)	7.3	7.4
5	Total Fertility Rate (NFHS-III)	2.1	2.7
6	Infant Mortality Rate (SRS 2007)	47	55
7	Maternal Mortality Ratio (SRS 2001 - 2003)	228	301
8	Sex Ratio (Census 2001)	965	933
9	Population below Poverty line (%)	20.04	26.10
10	Schedule Caste population (in millions)	8.56	166.64
11	Schedule Tribe population (in millions)	3.46	84.33
12	Female Literacy Rate (Census 2001) (%)	56.9	53.7

Table: 2 Health Infrastructure Karnataka[2]

Particulars	Required	In position	shortfall
Sub-centre	7369	8143	-
Primary Health Centre	1211	1679	-
Community Health Centre	302	254	48
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	9822	7244	2578
Health Worker (Male) MPW(M) at Sub Centres	8143	3762	4381
Health Assistant (Female)/LHV at PHCs	1679	1170	509
Health Assistant (Male) at PHCs	1679	837	842
Doctor at PHCs	1679	2041	-
Obstetricians & Gynecologists at CHCs	254	215	39
Physicians at CHCs	254	192	62
Pediatricians at CHCs	254	116	138
Total specialists at CHCs	1016	691	325
Radiographers	254	30	224
Pharmacist	1933	1472	461
Laboratory Technicians	1933	1242	691
Nurse/Midwife	3457	3100	357

RHS Bulletin, March 2007, M/O Health & F.W., GOI

Table: 3 Other Health Institutions in the State are detailed as under:

Name of pilot district	Name of District Nodal NGO	Name of Talukas in district	Name of Taluka nodal NGO
Tumkur	AID India	1. Pavagada 2. Madhugiri 3. Gubbi	1. Thamate - AID India 2. Jeevika 3. BGVS
Gadag	Bharatiya Gyan Vigyan Samiti (BGVS)	1. Rona 2. Gadag 3. Mundaragi	1. Samatha 2. KVK 3. BGVS
Chamarajnagar	Karuna Trust	1. Yelandur 2. Chamarajnagar 3. Kollegal	1. Karuna Trust 2. VGKK 3. Sisters of the Holy cross
Raichur	Community Health Cell (CHC) with Roovari	1. Raichur 2. Manvi 3. Devadurga	1. Roovari 2. JMS 3. Samuha

2.2 Institutional Arrangements

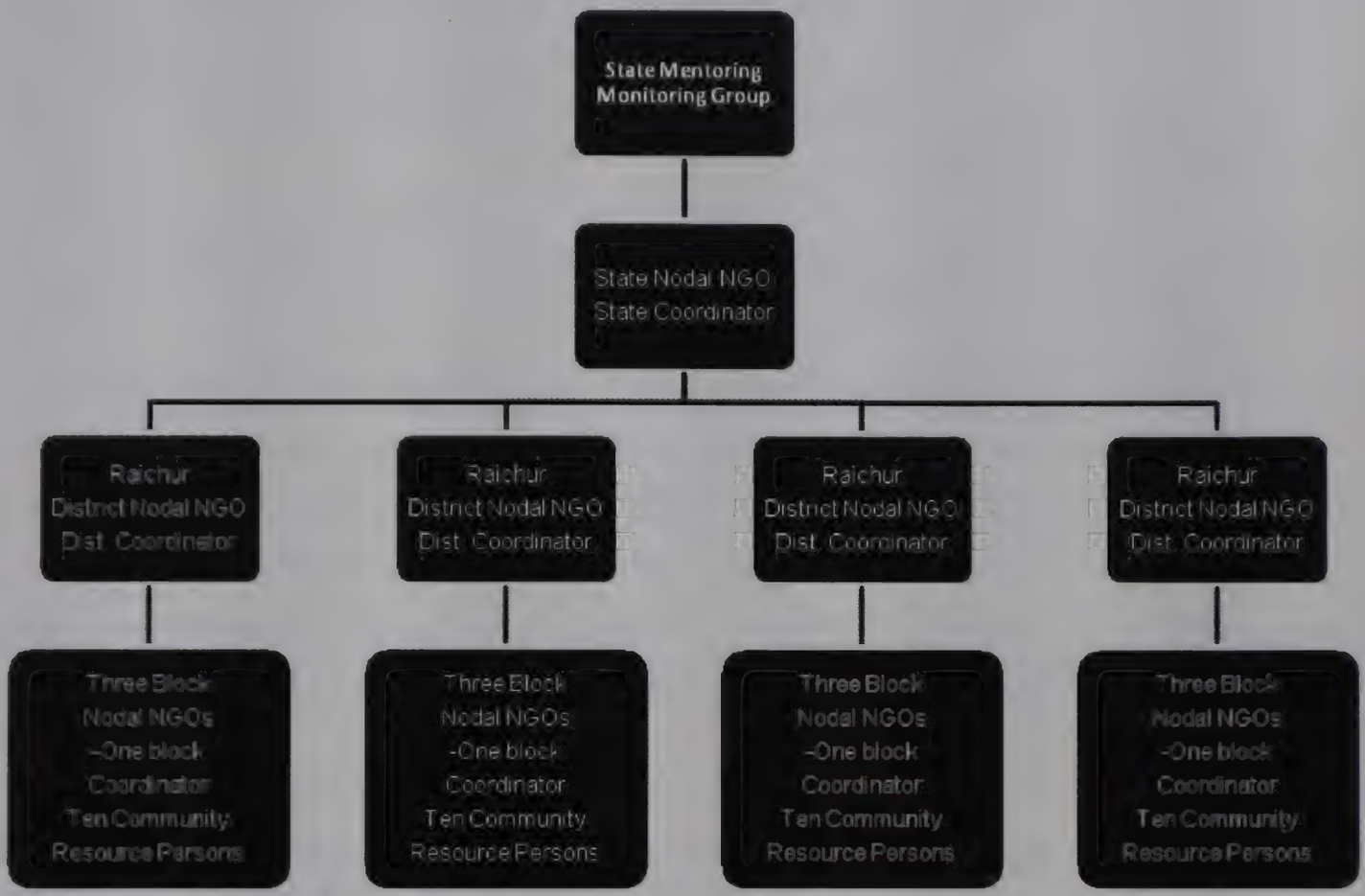
2.2.1 State Mentoring and Monitoring Group

The institutional mechanism designed at the national level was followed in Karnataka as well. In February 2008, a state mentoring and monitoring group (SMMG) was formally constituted by the state government. The SMMG, chaired by the Mission Director, was composed of three representatives from the health department (Director - Family Welfare, Director - State Institute of Health and Family Welfare, and Project Director - Reproductive and Child Health), the Director- Rural Development & Panchayat Raj and eight representatives from civil society organizations including two AGCA members (please refer to Table-4). The selection of organizations to be represented on the SMMG was made by the state government in consultation with the representatives of Karuna Trust and Community Health Cell who are also members of the AGCA at the national level. State representation on the SMMG was limited to the Health and PRI department.

The SMMG is an active body and met about three times over the process of implementation with full participation from state government. Apart from that, there were several meetings of civil society members of SMMG chaired by state nodal NGO to discuss the operational issues pertaining to implementation. Key decisions pertaining to project implementation were discussed extensively in the SMMG and were based on consensus. In some instances, for instance on the expansion of the CM to all villages in the PHC area, opinion was divided on the pace of the programme but majority vote prevailed. The leadership of the state nodal NGO and the high credibility of the other partnering NGOs made the SMMG in Karnataka an effective body.

Members of the SMMG also provided support for activities at the district and taluka levels with significant contribution especially given the pace of the intervention. SMMG members participated in the District and Taluka sensitization workshops as well as in the Training of Trainers at district levels. In addition some SMMG members also took part as resource persons and provided hand holding to block resource persons during the VHSC trainings. Figure-2 provides institutional structure for the programme.

Figure: 2 Institutional structure for CPMHS in Karnataka



2.2.2. State Nodal NGO

The state nodal agency selected by common consensus was Karuna Trust. Based on its outstanding work over the last few decades the Karuna Trust, has high credibility with the state government and other civil society organizations. Two state nodal coordinators were appointed by the state nodal NGO over the life of the project, but there was significant overlap between the two so that there were no lacuna and project activities continued unhindered.

The job responsibilities of the state nodal NGO coordinator were diverse and numerous. They included *inter alia,* convening meetings, liasioning with the national secretariat, members of the SMMG, support to the district coordinators in implementation, oversight to the translation of the

community monitoring material from English into Kannada, review of reports from districts, and documentation. The coordinators received substantial support from the state nodal NGOs and members of the SMMG in all tasks. Support to the project in terms of financial management and administration was provided by the state nodal NGO on a part time basis.

2.2.3. District Nodal NGOs

Four districts were selected for the implementation of the programme. Four NGOs represented on the SMMG, Community Health Cell (CHC), Bharat Gyan Vigyan Samiti (BGVS), Association for India's Development (AID), and Karuna Trust were selected to be the district nodal NGOs. Three of the organizations already had a district presence and representatives of the fourth have long standing connections with the district.

District nodal coordinators were appointed by the district nodal NGOs. Responsibilities of the district NGO coordinator included; liaison and networking with PRI, Health and allied departments, state NGO coordinator, support and supervision of block nodal NGOs, oversight and management of the implementation process of community monitoring, including trouble shooting and conflict resolution (given the nature of the process, and the social structure of the districts), documentation and reporting. Table-5 provides details on the Nodal NGOs for districts and Taluks.

2.2.4. Taluka (Block) Nodal NGOs

Three talukas per district were selected for implementation of the programme. Although three Taluka level NGOs were selected in each district, informal support was provided by several other organizations in

the Taluka that were committed to the process. As such the pilot initiative in the state has created consciousness and provided hands on implementation experience to several NGOs beyond the 12 Taluka NGOs.

Each Taluka Nodal NGO appointed one block coordinator and 10 community resource persons. Block Coordinators were responsible for the community monitoring process at the block level and for ensuring the quality of the process. Their task required a high level of understanding of community and of the public health system at block levels and below. In addition they were expected to network, and build relationships with the grass roots staff of the Health, ICDS and PRI departments. The block coordinators also had to guide and supervise the team of ten Community Resource Persons (CRP). CRPs 's main task was to orient VHSC members and to handhold them over the time.

Table: 4 Details of coverage and nodal NGOs at district and Taluka level

Name of pilot district	Name of District Nodal NGO	Name of Talukas in district	Name of Taluka nodal NGO
Tumkur	AID India	1. Pavagada 2. Madhugiri 3. Gubbi	1. Thamate - AID India 2. Jeevika 3. BGVS
Gadag	Bharatiya Gyan Vigyan Samiti (BGVS)	1. Rona 2. Gadag 3. Mundaragi	1. Samatha 2. KVK 3. BGVS
Chamarajnagar	Karuna Trust	1. Yelandur 2. Chamarajnagar 3. Kollegal	1. Karuna Trust 2. VGKK 3. Sisters of the Holy cross
Raichur	Community Health Cell (CHC) with Roovari	1. Raichur 2. Manvi 3. Devadurga	1. Roovari 2. JMS 3. Samuha

2.3 Processes

2.3.1 Selection of pilot districts, Talukas, PHCs and related NGOs

Selection of districts was made considering the following criteria.

- The district should have a strong presence of at least one civil society organization (CSO) working in health sector which can work as the lead NGO in that district.
- The districts chosen should be representative of social, economic, developmental, and cultural diversity of the state.
- The lead NGO should have strong linkages with the government and other CSOs working in health and development sector in that district.

Based on these criteria, four districts Chamarajnagara, Gadag, Raichur and Tumkur were selected. Selection of Taluks and PHCs was also based on the presence of NGOs in the vicinity and also consideration of whether these were border PHCs as past experience in the state demonstrates that these tend to be underperforming PHCs. Selection processes were transparent and made in consultation with the state leadership and district health authorities. The SMMG had considerable autonomy of selection and three of the four districts were selected by the SMMG, with Tumkur replacing Kolar as the government's choice. Figure-3 indicates the geographic locations of selected districts on the state map.

The state nodal NGO in consultation with members of the SMMG developed a matrix for selection of district and Taluka level NGOs. Based on this matrix, district and taluka level NGOs were selected. For details on District and Taluka Nodal NGOs please refer to Table-5.

Figure: 3 Pilot districts in Karnataka

2.3.2 Preparation and publication of training/awareness materials

State Mentoring Monitoring Group published many relevant publications to facilitate the CPMHS implementation in the state. Most of these materials were adopted from those prepared nationally by AGCA and national secretariat and were translated to local language.

- ***Training of Trainer's Manual (in Kannada language)***

A sub-committee formed by some of the SMMG members and other resource persons developed this manual by taking selected contents from national manuals (Manager's Manual, Monitoring Manual, Trainer's Manual) with some additional inputs and translation to local language. Objective of this manual was to help state level resource persons to conduct TOT at district level. However, the Manual was designed in a way that it also serve as a guide and further reading material for participants. It was distributed to all the district and Taluka coordinators as well as all the community resource persons.

- ***Brochure on CPMHS (in Kannada language)***

- ***Posters (in Kannada Language)***

In total 7 types of posters were published. The original posters published in English and Hindi by National Secretariat were translated in Kannada and adopted to the state schemes and context. Copies were supplied to VHSCs, Sub Health Centers, Anganwadi Centre, PHC etc.

- ***VHSC Manual (in Kannada Language)***

With the financial support from the state government, SMMG members, resource persons from other relevant organizations, and community workers together developed a manual for Village Health and Sanitation Committee through a state level workshop. The objective of this manual was to provide all the information that VHSC members need to know to effectively discharge their role a kind of a Bhagwad Gita for VHSC. Over the time, based on the experiences, this manual was further reviewed

and refined through another state level workshop. Copies of this manual were provided to all the members of VHSCs.

- ***Score cards, facility check lists & Process documentation formats***

The score-cards and facility checklists to be filled by VHSC were translated in local languages. Score cards were somewhat modified to make it easier for VHSCs to understand and fill the cards. Also the process documentation formats were translated in Kannada and distributed to district and taluka nodal NGOs.

2.3.3 Community mobilization

Kala Jatha

Kalajatha, street play, has been a very innovative and successful strategy in raising awareness and mobilizing communities. Each district selected a team of around 10-15 rural folk artists and 5 such teams were trained through a state level workshop on issues related to community monitoring and health in general. These skits were based on the issues like ASHA, VHSC formation, Role of VHSC etc. These Kalajatha teams then visited all the selected villages and performed street plays. These performances attracted many villagers and proved to be very effective in mobilizing rural folks and raising awareness among them on various health entitlements under NRHM and processes of CPMHS. Kalajatha performances also facilitated acceptance of marginalized groups by general community

Apart from Kalajatha performances, Taluk coordinators, and CRPs, assisted by the district coordinators conducted several meetings in the villages before the process of VHSC training. This ensured representation of marginalized communities in the VHSC as well as their participation in the training.

2.3.4 Sensitisation workshops

At the state level, two workshops of 2 days each were organized with involvement of SMMG, officers from state and district health department, PRI members and NGOs from the districts to sensetise these stakeholders on community monitoring processes. After this initial sensitization, state government also called on for a 2 days state level planning cum sensitization workshops that helped to develop a shared vision of the future processes and outputs.

Apart from this, one day sensitisation workshops were held at district and taluka levels at the respective health centres / facilities by district and Taluka nodal NGOs. The main objectives of these workshops were to sensitise people within health systems and ensure buy in and ownership.

2.3.5 Capacity building/training workshops

After an initial planning workshop at state level among SMMG members, a 5 days training of trainers (TOT) workshops were organized in each district. The objective of these TOT workshops was to train community resource persons from all the blocks so that they can go back and train VHSC members.

District Nodal NGO with help from state coordinator organized all the logistics for the TOT workshop. Members from SMMG and sometimes people from the district served as resource persons for such trainings. First two days included theoretical sessions through group work and followed by three days of field training. Activities for these 5 days were scheduled as follow.

Day-1: Introduction, What is health? Equity, Social determinants of health, Rights & Health rights, Public Health System
Day-2: NRHM, Community Monitoring under NRHM, Why community participation? PRA Technique, Monitoring tools and mechanisms

Day -3: Interaction with VHSC, Transect walk, Village mapping
Day-4: Group discussions with community groups and filling the scorecards, Facility visit and filling the facility checklist
Day 5: Village Health Plan, Sharing the findings with villagers (Gram Sabha), Jan Samvad, Action plan

Of all the CRPs trained in such way, some dropped out later on and also CRPs felt a need for further inputs on particular issues like feeling up score cards etc. Hence, in the second phase a 3 days training was imparted to all the CRPs through district level workshops.

2.3.6 Formation of Committees at various levels

As showed in the Figure-1, committees at several levels were anticipated in the national design. They include the Village health and Sanitation Committee, the PHC Monitoring and Planning Committee, the Block Monitoring and Planning Committee, the District Monitoring and Planning Committee, and the State Monitoring and planning Committee. Given the late inclusion of the Karnataka for this programme, only VHSCs have been formed and strengthened.

Village Health and Sanitation Committees

A large number of VHSCs had been formed through a Government Order issued after the launch of the NRHM in the state. However taluka coordinators and the block CRP in all districts realized the non-existing or non-functioning VHSCs in most villages.

Taluka coordinators visited all the PHCs to collect a list of VHSC members in the selected villages. They then visited each village, located VHSC members and interacted with them explaining them about the CPMHS and the orientation process. They fixed the dates for the VHSC orientation. Taluka coordinators and CRPs spent significant time to

revitalize, reconstitute and strengthen the VHSC in order to ensure that the composition of the committees included marginalized populations, minorities and women in proportion to the demographic composition in the village. Block CRPs had to conduct several meetings with separate caste groups to ensure buy in before the Gram Sabha was held to finally nominate / re-nominate members to the VHSC. Due to efforts of block NGOs, VHSC composition as mandated by the guidelines had been faithfully adhered to with due representation of all communities and caste groups.

VHSC Orientation

A team of three CRPs, supported by the block coordinator conducted the VHSC training in each village, with the duration of training lasting for three days. Only few VHSC had 100% participation on all three days. AWW who were nonresident did not come about 30% to 50% of the time for all three days. In areas where there was a GO from Taluka Executive Officer and ICDS, there was better attendance of AWW and PRI.

Activities for the 3 days orientation were scheduled as follow.

Day 1: Theory regarding Health / ill health, NRHM, VHSC- Aim, formation, role and responsibilities, Untied fund, Monitoring and planning activities etc.

Day 2: PRA technique, Community monitoring exercises FGDs with community groups, facility visits etc. filling up score cards

Day 3: Village health plan, Sharing of 2 days' experience at Gramsabha, Sharing the score cards, village health plan, Fixing the follow-up meeting etc.

In the phase-1, VHSCs in all the selected 180 villages from 15 PHCs were oriented. However, later on, SMMG in coordination with district NGOs decided to expand the coverage to achieve universal coverage within selected 15 PHCs and to cover one more PHC per district.

This resulted in a total coverage of 562 villages where VHSCs were reconstituted and trained.

Table: 6 provides district wise detailed coverage

Name of pilot district	Name of Taluka nodal NGO	Number of PHC (four per block)	Total number of VHSC
Tumkur	1. Tamata 2. Jeevika 3. BGVS	12	Phase 1: 45, Phase 2:120 Total : 165
Gadag	1. Samatha 2. KVK 3. BGVS	13	Phase 1: 44, Phase 2: 65 Total : 109
Chamarajnagar	1. Karuna Trust 2. VGKK 3. Sisters of the Holy cross	12	Phase 1: 45, Phase 2: 93 Total: 138
Raichur	1. Roovari 2. JMS 3. Samuha	12	Phase 1:45, Phase 2: 105 Total: 150

2.3.7 Village Report Cards and Village Health Plans

During the training of VHSCs, as a part of the training, CRPs along with VHSC members filled the first round of score cards and facility checklists. Also at the end of the 3 days VHSC training, village action plans were prepared. However, following the training, till now, at least three rounds of score cards have been prepared by VHSC members facilitated by CRPs. The score card format was perceived as very complex and as a result, the filling of the score card has entailed much time and efforts. SMMG revised the format to make it understand how to fill it. However, some of the parameters within the format itself were found difficult to understand by district and block coordinators leave apart the VHSC members. For example, equity 'Equity Index' remains unfilled in a large majority of the cards because of difficulties in understanding what it means and how it needs to be arrived at. The facility check lists for Sub Centres and PHCs have also been completed.

A brief analysis of these score cards from 3 rounds has been presented in section 3.

2.3.8 Jan Samvad (Public Dialogue)

In all the selected PHCs, Jan Samvads were held. At a typical Jan Samvad, Taluka Health Officer, PHC Medical Officer, ANM, Anganwadi workers, SHG members, NGO representatives were present. VHSC members from the selected villages shared Score Cards and their experiences including any case studies of positive or negative health outcomes. They shared their village health plans. PHC level Jan Samvad were followed by district level Jan Samvads. Elaborative preparations were made with the district team conducting village meetings with the VHSC to identify case studies/testimonials to be brought before the public hearing. Common issues raised by the Jan Samvad include: Corruption, non receipt of funds under JSY, non receipt of Madilu kit, malnutrition at village level, non use of untied funds because of lack of proper guidelines, referral to district hospital without proper reference documents, poor infrastructure in sub center, denial of delivery services, staff vacancy at all levels, where good staff are available, they are stretched too thin, (great MO but being sent off everywhere as a resource persons), apathy of health system, poor infrastructure at PHC, Lack of facilities: water, electricity, doctors not residential because of poor living quarters, no anti snake venom, TB medicine. Unfortunately, the emphasis appeared more to highlight the shortcomings of the system, including corruption.

2.3.9 Media

In all pilot districts the district coordinator has networked with local media to enable periodic articles in the vernacular press about the process and ensuring coverage to the Jana Samwada. This has yielded results particularly with publicity in regional language newspapers. However the coverage varied across the districts. In Gadag district, one of the block coordinator happened to be a media professional and hence able to ensure that several articles in print media.

Progress and outputs of CPMHS An overview

This section provides a brief overview on outputs of CPMHS in Karnataka. As mentioned earlier, at least, 180 villages from 4 districts covered initially under Phase I of CPMHS were able to generate 3 rounds of village report cards. Village report cards filled by VHSC members periodically, provides status and community perceptions on 11 key health/health service parameters e.g. Maternal Health Guarantee, Child Health, Community perceptions of ASHA functioning etc. Village report cards doesn't provide quantitative data (e.g. how many children immunized/not immunized) but provides an overall rating on three categories of Red, Yellow or Green; Red meaning worst while Yellow and Green indicates moderate and good outputs for that particular parameter respectively. This categorization (of Red/Green/yellow) is made based on quantitative/qualitative data generated through following methods at a village level.

- Focus Group Discussions with community members, mothers
- Individual interviews with ASHA, ANM
- Individual interviews with JSY beneficiaries

The format of the village report card was adopted from the national guidelines and was simply translated in local language. Some of these parameters and the methods required to assess these parameters were perceived complex not only by VHSC members but also the district and block coordinators. To address these difficulties, the second phase of 3 days TOT for CRPs had a specific focus on building their skills to fill the report cards. Also, SMMG members revised the format and presentation of the village report card and methods to fill the cards but without changing the content/parameters. Overall, the report card was perceived complex and the utility was not clear to a significant proportion of VHSC members. One of the parameter in the village report card i.e. 'Equity Index' remained blank in most of the report cards by VHSCs. On the other hand, during the first phase of implementation, in most of the pilot villages, ASHAs were either not appointed or were just appointed awaiting training. Hence, the first round of report cards doesn't provide status of 'ASHA functioning' and 'Community perceptions on ASHA'. The Figure 4 provides a snapshot of the cumulative findings for four districts on eight parameters of village report cards generated by VHSCs in three rounds over a period of around 6 months.

- Individual interviews with ASHA, ANM
- Individual interviews with JSY beneficiaries

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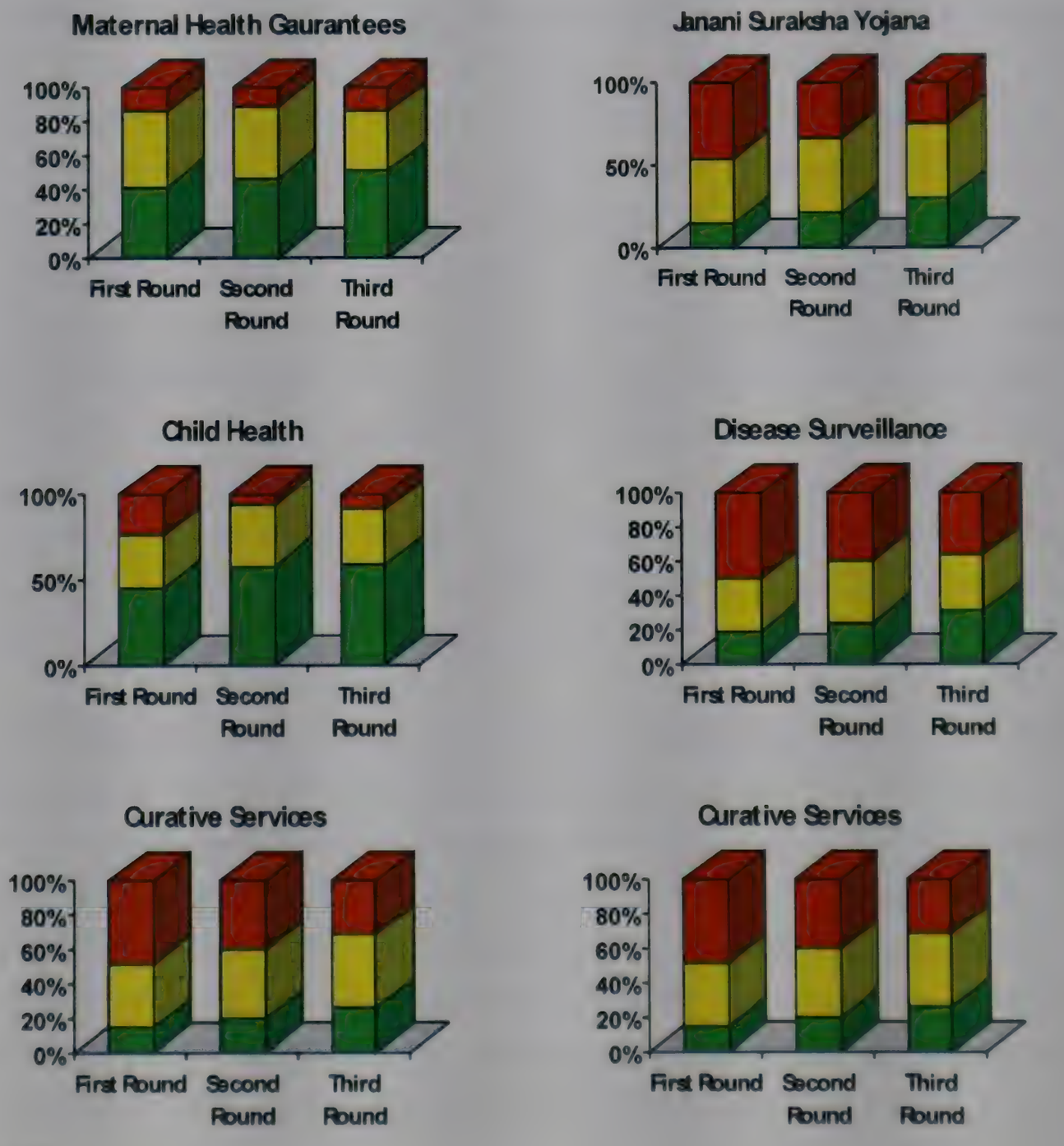
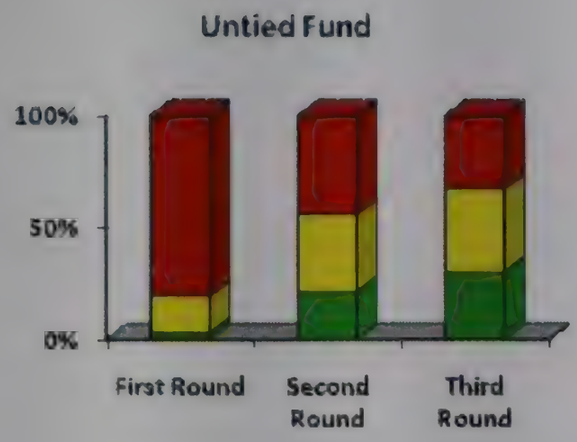
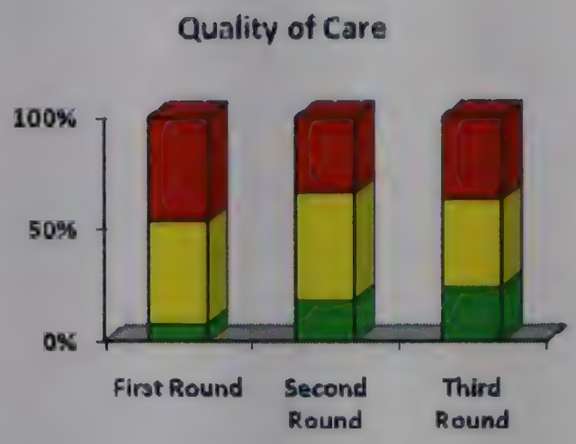
Figure: 4 Village report card analyses (Cumulative of four districts)

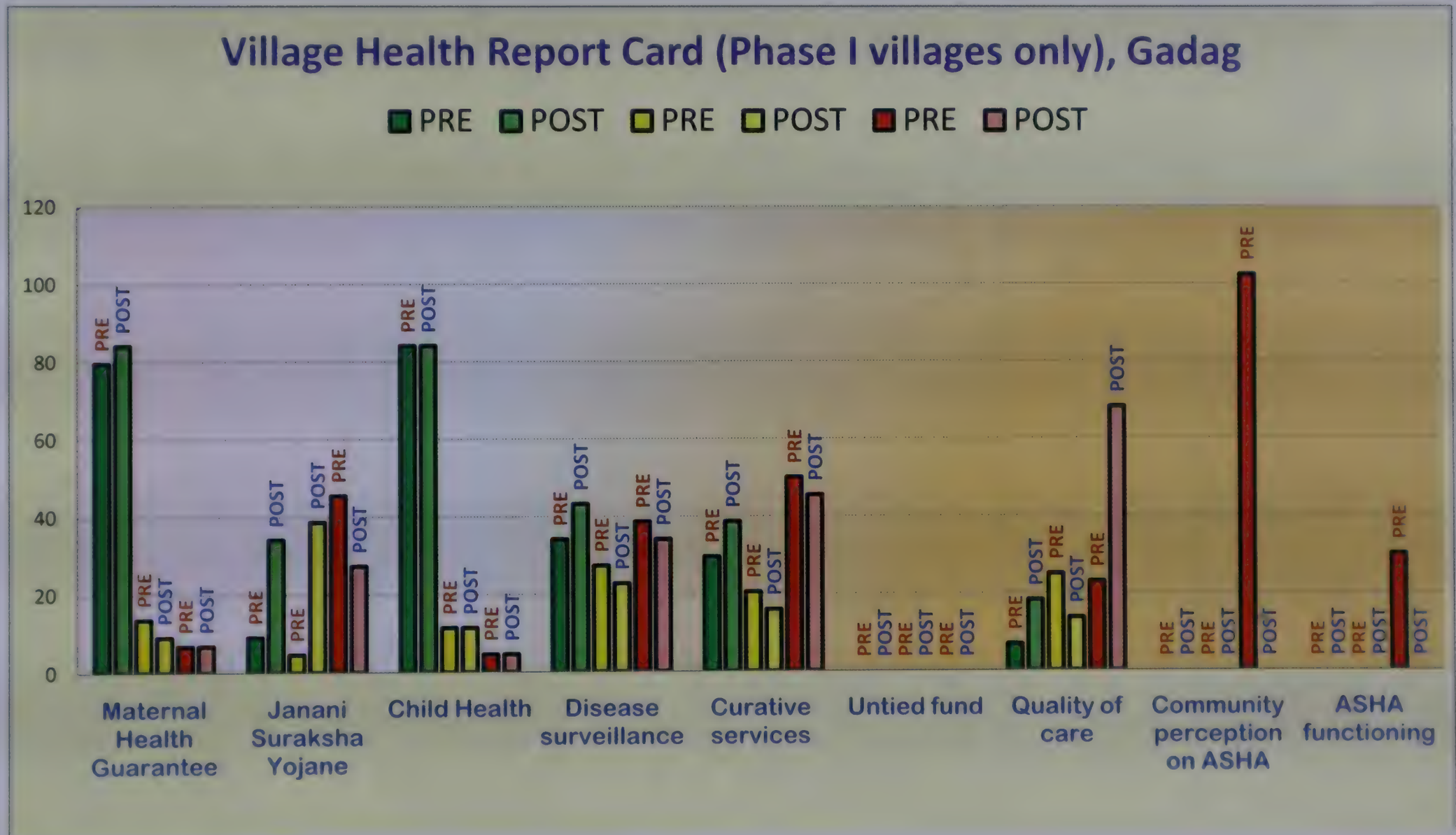


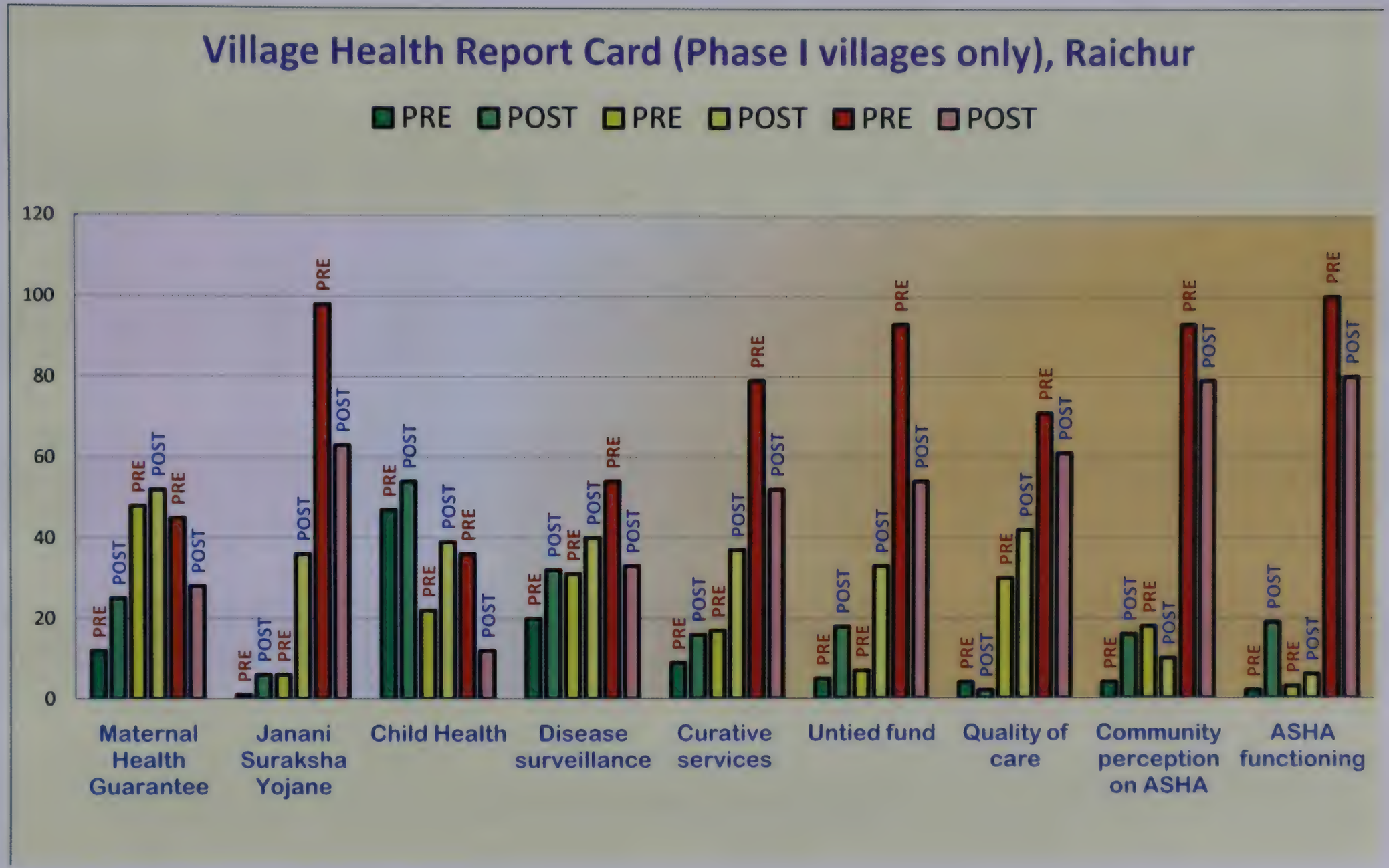


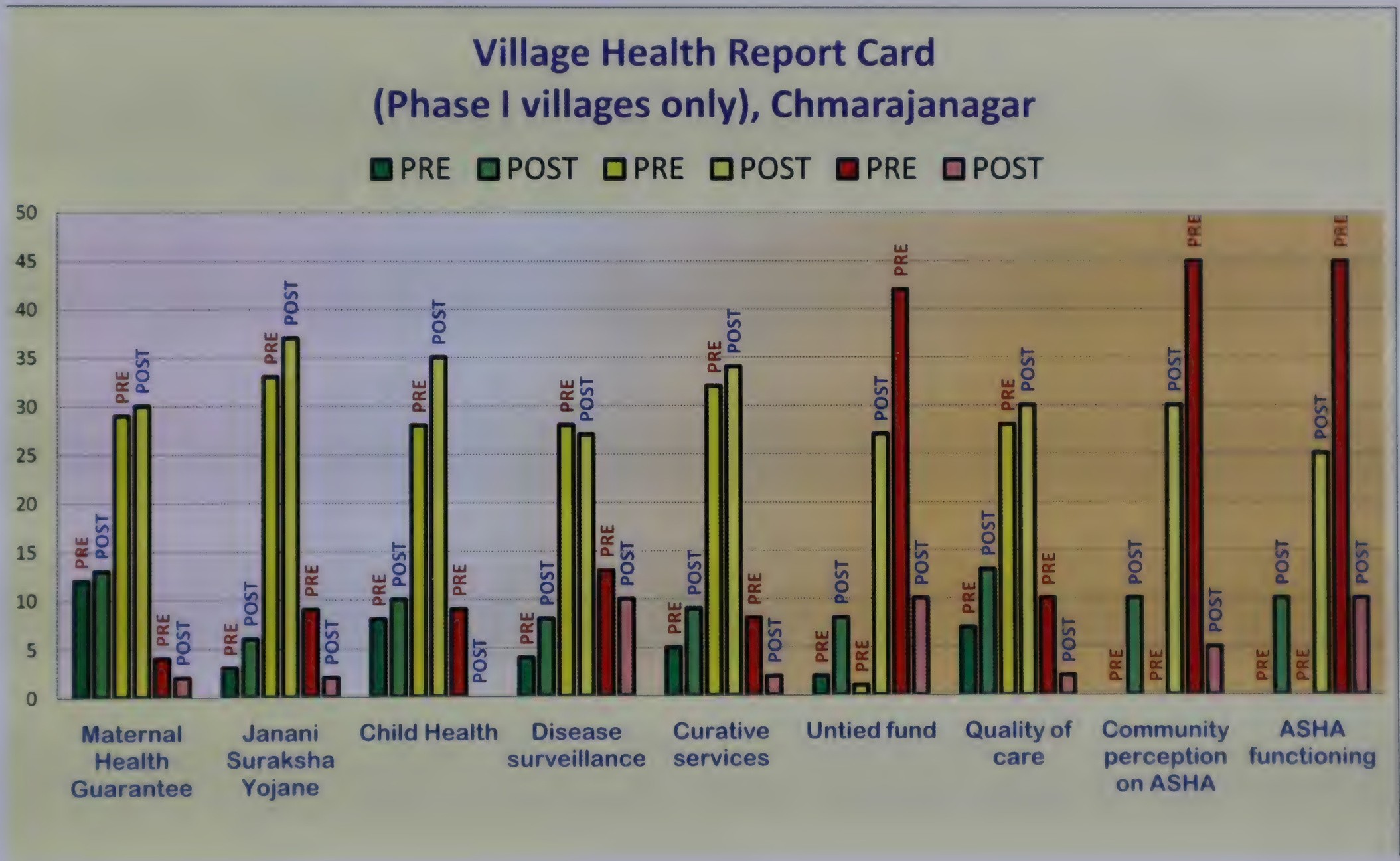


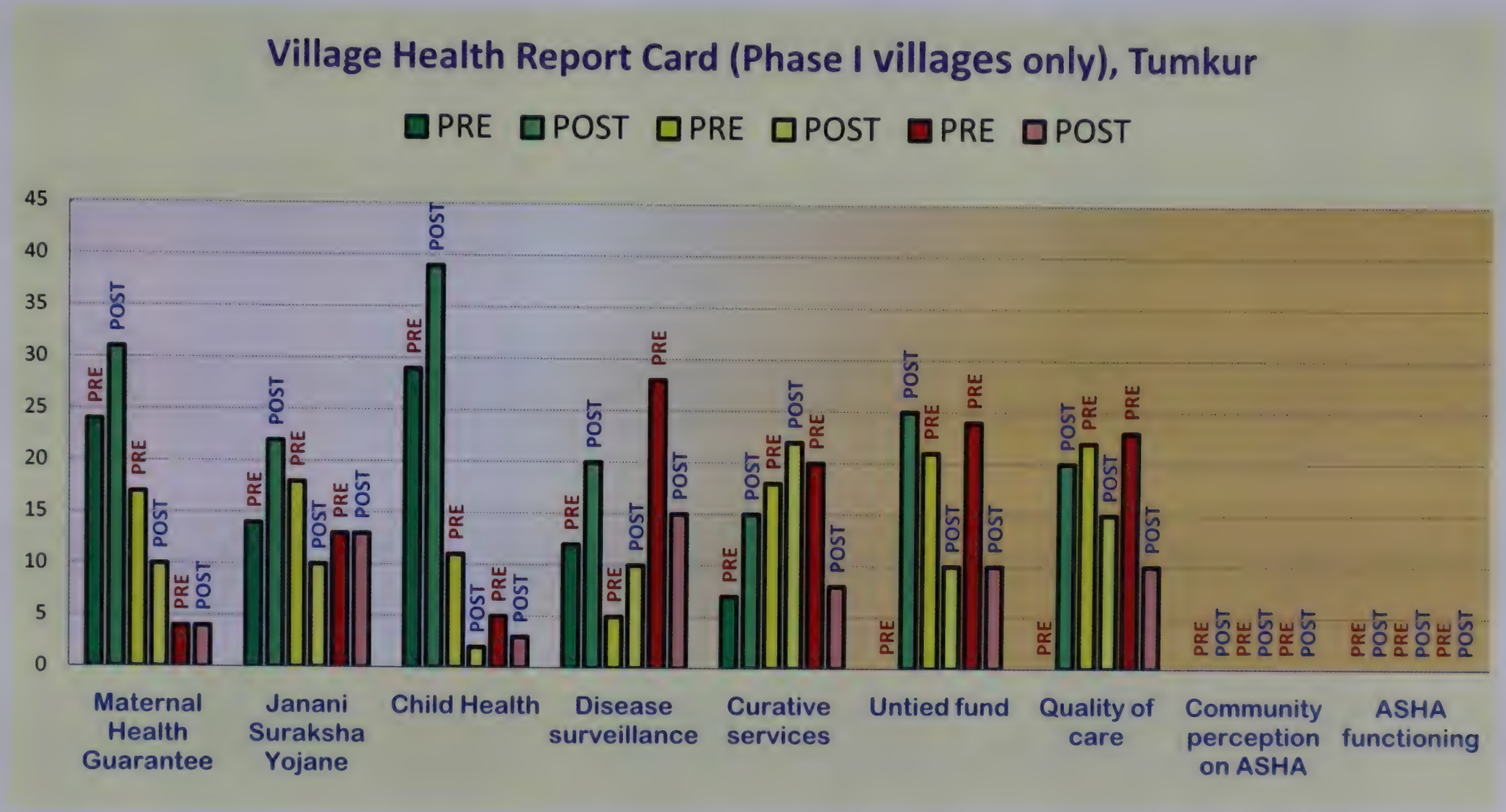
Analysis of the score cards shows the perceptions of community members on various health and health service parameters. It makes evident the poor status of quality of care and utilization of untied fund while child health fares comparatively better. On the whole, over the project period, all the parameters show differential degree of progress (RED signs decreasing while an increase in Yellow and Green signs). Jan Samvads have resulted in action being taken in some areas - such as use of untied funds at PHC and SC level for repairs and equipment or Posting of health personnel in some cases. Please refer to Annex-1 for district wise findings. Apart from the village report cards, VHSCs filled the facility level check lists for Health Sub Centres and PHCs. However, unlike, village report cards, these facility checklists have been generated only once till now. Hence these check lists rather provide a baseline status. Please refer to Annex-2 for district wise cumulative findings from facility check lists.

The process has also resulted in more accurate reporting of deaths. For instance in the last six months, in one Taluka alone, the VHSC process has identified six infant deaths and one maternal death which were not picked up by the system. Annex-2 depicts a few case studies demonstrating the changes within the health services as a result of the CPMHS in Karnataka


Village Health Report Card (Phase I villages only), Gadag
PRE
POST
PRE
POST
PRE
POST
120
100
80
60
40
20
0
Maternal Health Guarantee
Janani Suraksha Yojane
Child Health
Disease surveillance
Curative services
Untied fund
Quality of care
Community perception on ASHA
ASHA functioning


Village Health Report Card (Phase I villages only), Raichur
PRE
POST
PRE
POST
PRE
POST
120
100
80
60
40
20
0
Maternal Health Guarantee
Janani Suraksha Yojane
Child Health
Disease surveillance
Curative services
Untied fund
Quality of care
Community perception on ASHA
ASHA functioning


Village Health Report Card
(Phase I villages only), Chmarajanagar
PRE POST PRE POST PRE POST
50
45
40
35
30
25
20
15
10
5
0
Maternal Health Guarantee
Janani Suraksha Yojane
Child Health
Disease surveillance
Curative services
Untied fund
Quality of care
Community perception on ASHA
ASHA functioning


Village Health Report Card (Phase I villages only), Tumkur
PRE
POST
PRE
POST
PRE
POST
45
40
35
30
25
20
15
10
5
0
Maternal Health Guarantee
Janani Suraksha Yojane
Child Health
Disease surveillance
Curative services
Untied fund
Quality of care
Community perception on ASHA
ASHA functioning

Village Health Report Card (Phase I villages only) Chamarajanagar																								
	FIRST ROUND								SECOND ROUND								THIRD ROUND							
Indicators	Green		Yellow		Red		Total		Green		Yellow		Red		Total		Green		Yellow		Red		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Maternal Health Guarantee	12	27	29	64	4	9	45	100	12	27	31	69	2	4	45	100	13	29	30	67	2	4	45	100
Janani Suraksha Yojane	3	7	33	73	9	20	45	100	4	9	35	78	6	13	45	100	6	13	37	82	2	4	45	100
Child Health	8	18	28	62	9	20	45	100	8	18	37	82	0	0	45	100	10	22	35	78	0	0	45	100
Disease surveillance	4	9	28	62	13	29	45	100	4	9	31	69	10	22	45	100	8	18	27	60	10	22	45	100
Curative services	5	11	32	71	8	18	45	100	5	11	35	78	5	11	45	100	9	20	34	76	2	4	45	100
Untied fund	2	4	1	2	42	93	45	100	2	4	21	47	22	49	45	100	8	18	27	60	10	22	45	100
Quality of care	7	16	28	62	10	22	45	100	7	16	32	71	6	13	45	100	13	29	30	67	2	4	45	100
Community perception on ASHA	0	0	0	0	45	100	45	100	0	0	30	67	15	33	45	100	10	22	30	67	5	11	45	100
ASHA functioning	0	0	0	0	45	30	45	30	0	0	30	67	15	33	45	100	10	22	25	56	10	22	45	100

Village Health Report Card (Phase I villages only) Gadag																						
	FIRST ROUND								SECOND ROUND								THIRD ROUND							
Indicators	Green		Yellow		Red		Total		Green		Yellow		Red		Total		Green		Yellow		Red		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Maternal Health Guarantee	35	80	6	14	3	7	44	100	37	84	4	9.1	3	6.8	44	100	37	84	4	9.1	3	6.8	44	100
Janani Suraksha Yojane	4	9	2	4.5	20	45	44	59	8	18	20	45	16	36	44	100	15	34	17	39	12	27	44	100
Child Health	37	84	5	11	2	5	44	100	37	84	5	11	2	4.5	44	100	37	84	5	11	2	4.5	44	100
Disease surveillance	15	34	12	27	17	39	44	100	19	43	10	23	15	34	44	100	19	43	10	23	15	34	44	100
Curative services	13	30	9	20	22	50	44	100	13	30	9	20	22	50	44	100	17	39	7	16	20	45	44	100
Untied fund	0	0	0	0	0	0	44	0	0	0	0	0	0	0	44	0	0	0	0	0	0	0	44	0
Quality of care	3	7	11	25	30	23	44	55	5	11	9	20	30	68	44	100	8	18	6	14	30	68	44	100
Community perception on ASHA	0	0	0	0	45	102	44	102	0	0	0	0	0	0	44	0	0	0	0	0	0	0	44	0
ASHA functioning	0	0	0	0	0	30	44	30	0	0	0	0	0	0	44	0	0	0	0	0	0	0	44	0

Village Health Report Card (Phase I villages only) Raichur																						
	FIRST ROUND								SECOND ROUND								THIRD ROUND							
Indicators	Green		Yellow		Red		Total		Green		Yellow		Red		Total		Green		Yellow		Red		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Maternal Health Guarantee	2	4	28	62	15	33	45	100	7	16	27	60	11	24	45	100	9	20	20	44	16	36	45	100
Janani Suraksha Yojane	2	4	11	24	32	71	45	100	8	18	12	27	25	56	45	100	10	22	18	40	17	38	45	100
Child Health	5	11	12	27	28	62	45	100	29	64	12	27	4	9	45	100	17	38	17	38	11	24	45	100
Disease surveillance	2	4	10	22	33	73	45	100	7	16	19	42	19	42	45	100	8	18	11	24	26	58	45	100
Curative services	0	0	7	16	38	84	45	100	8	18	11	24	26	58	45	100	5	11	13	29	27	60	45	100
Untied fund	2	4	1	2	42	93	45	100	7	16	16	36	22	49	45	100	7	16	14	31	24	53	45	100
Quality of care	1	2	7	16	37	82	45	100	6	13	25	56	14	31	45	100	2	4	20	44	23	51	45	100
Community perception on ASHA	0	0	2	4	43	96	45	100	2	4	3	7	40	89	45	100	4	9	4	9	37	82	45	100
ASHA functioning	0	0	0	0	45	100	45	100	1	2	1	2	43	96	45	100	4	9	4	9	37	82	45	100

Village Health Report Card (Phase I villages only) Tumkur																						
	FIRST ROUND								SECOND ROUND								THIRD ROUND							
Indicators	Green		Yellow		Red		Total		Green		Yellow		Red		Total		Green		Yellow		Red		Total	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Maternal Health Guarantee	24	53	17	38	4	9	45	100	26	58	15	33	4	8.9	45	100	31	69	10	22	4	8.9	45	100
Janani Suraksha Yojane	14	31	18	40	13	29	45	100	16	36	16	36	13	29	45	100	22	49	10	22	13	29	45	100
Child Health	29	64	11	24	5	11	45	100	29	64	11	24	5	11	45	100	39	89	2	4.5	3	6.8	44	100
Disease surveillance	12	27	5	11	28	62	45	100	12	27	5	11	28	62	45	100	20	44	10	22	15	33	45	100
Curative services	7	16	18	40	20	44	45	100	8	18	17	38	20	44	45	100	15	33	22	49	8	18	45	100
Untied fund	0	0	21	47	24	53	45	100	20	44	10	22	15	33	45	100	25	56	10	22	10	22	45	100
Quality of care	0	0	22	49	23	23	45	72	15	33	20	44	10	22	45	100	20	44	15	33	10	22	45	100
Community perception on ASHA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ASHA functioning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0


ಸುಸೂತ್ರ ಪಯಣಕ್ಕಾಗಿ
ನಮ್ಮೂರ ಸೇವೆಯ ಖಾತ್ರಿ

Lessons from Karnataka
Challenges and Learnings

4.1 Facilitating factors

- Then Mission Director Mr. Madan Gopal, I.A.S., visited several districts and raised awareness among DHOs about NRHM and Community Monitoring.

- Efforts by the Mission Director to enable State level NGO co-coordinator to form better linkages between the Government and the Civil Society.

- Prior working relationship of most District NGOs with Block level NGOs was very helpful.

- Partner organisations facilitated trainings with all constraints.

- An institution called ISHA supported the workshop by providing facilities on concession.

- Gram Panchayats cooperated for conducting the Gram Sabha to form the VHSCs as per the guideline. Also took initiatives to prepare the village health plan at the time of the VHSC trainings / meetings.

- Two experienced theatre persons involved in training of 'Kalajatha' team.

4.2 Challengers / Problem Faced / Concerns

- Backlog of NRHM implementation in the state.

- Delay in recognition of State Mentoring Group. State NRHM unit initiated the process and issued circulars from department.

- Village Health and Sanitation Committees had been sanctioned through a government order without going through any of the processes recommended. Issues raised were whether existing VHSCs could be annulled if found incompetent / unrepresentative.

- No regular updates on progress of NRHM available.
- Karnataka State does not have a website for the Health
- Poor knowledge among government staff about NRHM and community planning & monitoring.
- Process of community monitoring came across as confrontational. It was decided to avoid using data that had already been collected by Government officials. The Government might use the community monitoring channel to fulfill a policing role (e.g., information regarding poor reporting to be used as a disciplinary tool).
- Concern that it would focus only on RCH similar to other programmes.
- Government officials unwilling to come with a Government order at various levels.
- It took more time in organising the workshop against planned, coordination between departments was difficult.
- It took lot of effort and energy to appraise the district officials.
- More cooperation needed at district level.
- Insufficient time and shortage of resource persons.
- In the 1st phase, due to miscommunication from national secretariat, state didn't have enough money for media activities.
- Format filling, no clear cut information on formation of monitoring committees are various levels. Doubts on filling the format and formation of committees were clarified.
- Occasionally, the meetings of State had been called at very short notice and, in such a situation, it was difficult to have most of the members attending the meetings. As a result, members tried to avoid making important decisions and postponing such agenda to next meetings where most members could attend and contribute.

- It was difficult to identify the members of VHSC since the committee formation was only on paper. In some of the places committees were not formed as per the guideline. Members were called during the Gram Sabha, introduced to the public and in some places the committees were reformed as per the guide line.

- Time was very short and people were busy in agricultural activities. Occasionally VHSC members expected some monetary returns to participate in the training. People were motivated through environment building like Kalajatha, prior visit by block coordinator and others.

- Some of the points in the score card need more clarity e.g., equity index. Repeated visits and short term trainings solved the problem. Some modifications were made for score cards.

- In the 1st phase, due to miscommunication from national secretariat, state didn't have enough money for media activities. In the first phase, no dedicated media people were hired. Instead, district team approached media through press conferences at different occasions.

- District NGOs addressed Government Staff in their own districts rather than converge them at the State level.

- In the first phase, no dedicated media people were hired. Instead, district team approached media through press conferences at different occasions.

4.3 Learning:

- The fact that a rapid roll out was possible despite the late inclusion of the state for CPMHS processes indicates the potential for scaling up of this model.

- SMMG with the virtues of having 1) two AGCA members, 2) the NGOs that worked together in the past on the common platform

and exhibited shared commitment 3) senior state government officers that exhibited willingness and commitment to the process and worked in close partnership with NGOs helped to positively influence the pace, processes and outputs to a great extent.

- Facilitation by NGOs is crucial as no other institutions can undertake various complex functions related to community monitoring. Involvement of NGOs as nodal agencies at state, districts and block levels along with informal involvement of other NGO partners at various levels in particular the district and sub-district levels was critical in achieving the desired community processes such as assuring representation of marginalized communities on VHSCs, raising awareness and interest among communities for CPMHS etc.

- Use of Kalajataha (street play) and numerous meetings by block NGOs (block coordinators and CRPs) with communities prior to VHSC training and then constant handholding of VHSCs over the time through periodic visits have been resource intensive processes, both in terms of human resource and time, but yielded results in terms of community mobilization, confidence and capacity building of VHSCs, etc. This heavy investment in community processes is inevitable to successful CPMHS.

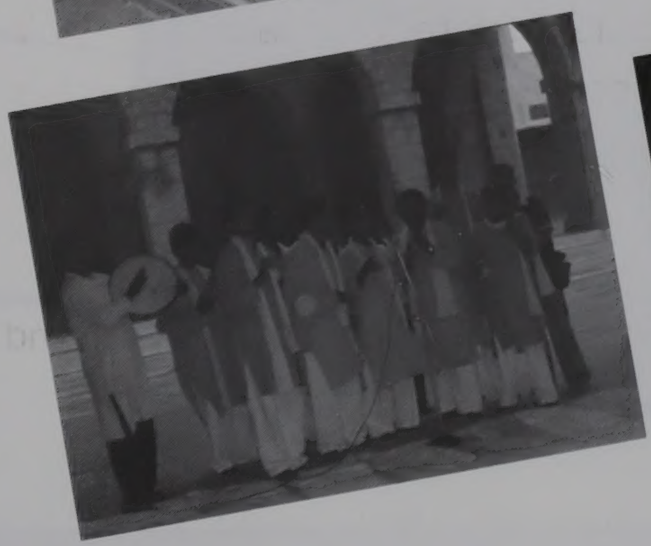
- Sensitisation and constant engagement with service providers at various levels from district hospital to Sub Centre level is very important. Higher level officers at state particularly the Secretary (Health and Family Welfare) and the Mission Director (NRHM) showed commitment and ownership but such ownership was not translated to lower levels such as Taluka Health Officer, PHC MO etc. Though sensitisation workshops

for health providers at district and sub-district level helped but yet NGOs had to strike a delicate and often fragile balance with health system providers. On the other hand, NGOs and their staff, often had different perspectives on CPMHS processes and often lacked understanding of public health system. Perspective building of staff of NGOs on public health systems in conjunction with sensitization of health providers is critical to ensure that all participants have a common framework of understanding.

- Village report cards or in that sense any monitoring parameters at village level that are to be monitored by VHSC members need to be simple to understand and assessed by VHSC members and should hold meaning for the people and providers at that level. Simple parameters like deaths, births, JSY benefits, immunization, availability of health staff/facilities etc. were regularly monitored and reported by VHSC members with interest. However some of the complex parameters like, Equity Index (to be measured through differential assessment of some of the parameters among general and marginalized communities) remained unfilled.

- Involvement of sectors other than health is very much needed given the intersectroral nature of health and to engage functionaries from these sectors. Though PRI members were the part of VHSCs, their involvement was relatively low. Though, AWWs were very much involved at VHSCs level (particularly in absence of AHSA, they served as convener of VHSC) and were very active, Dept. of Women and Child Welfare was otherwise not involved at SMMG or District/Taluka levels. Also ASHA's involvement will need to be skillfully managed as she comes on board. Limitations of time and human resources constrained strengthening of these cross linkages.

- In Karnataka, community processes were extended beyond community monitoring to include planning by community (in form of village action plans). These community processes for CPMHS helped to raise awareness on various health issues, entitlements, and services and mobilize communities for collective action. All the parameters that VHSCs were able to monitor revealed varying degree of progress over the time. Also, interactions between community and service providers (Jan Samvada) resulted in positive actions taken by service providers in some instances. However, such positive actions were often the knee-jerk responses by district providers with little consideration for community needs and long term solutions.



ಹಳ್ಳಿಯ ವರದಿ ಕಾರ್ಡು

ಹಳ್ಳಿಯ ವರದಿ ಕಾರ್ಡಿನ ನಮೂನೆ

ದಿನಾಂಕ :

ಗ್ರಾಮದ ಹೆಸರು : ತಾಲ್ಲೂಕು : ಜಿಲ್ಲೆ :

ಕ್ರ.ಸಂ	ವಿಷಯ	ಅಂಕ	ಮಧ್ಯಪ್ರವೇಶ	ಟ್ರಾಫಿಕ್ ಲೈಟ್
1.	ತಾಯಿ ಆರೈಕೆಯ ಖಾತ್ರಿಗಳು (ಪಟ್ಟಿ – 12)		75% ಜನ → ಹಸಿರು 50–74% ಜನ → ಹಳದಿ 50% ಗಿಂತ ಕಡಿಮೆ → ಕೆಂಪು	
2.	ಜನನಿ ಸುರಕ್ಷಾ ಯೋಜನೆ (ಪಟ್ಟಿ – 13)		75% ಜನ → ಹಸಿರು 50–74% ಎನ್ → ಹಳದಿ 50% ಗಿಂತ ಕಡಿಮೆ → ಕೆಂಪು	
3.	ಮಕ್ಕಳ ಆರೋಗ್ಯ (ಪಟ್ಟಿ – 4 + 5)		31–40 → ಹಸಿರು 25–30 → ಹಳದಿ 0–24 → ಕೆಂಪು	
4.	ರೋಗ ಕಣ್ಗಾವಲು (ಪಟ್ಟಿ – 01)		8–10 → ಹಸಿರು 7–5 → ಹಳದಿ 0–4 → ಕೆಂಪು	
5.	ಪ್ರತಿಬಂಧಕ ಸೇವೆಗಳು (ಪಟ್ಟಿ – 02)		10–12 → ಹಸಿರು 7–9 → ಹಳದಿ 0–6 → ಕೆಂಪು	
6.	ಮುಕ್ತ ನಿಧಿ (ಪಟ್ಟಿ – 03)		7–8 → ಹಸಿರು 5–6 → ಹಳದಿ 0–4 → ಕೆಂಪು	
7.	ಸೇವಾ ಗುಣಮಟ್ಟ (ಪಟ್ಟಿ – 08 + 09)		19–24 → ಹಸಿರು 12–18 → ಹಳದಿ 0–11 → ಕೆಂಪು	
8.	ಆಶಾ ಕುರಿತು ಸಮುದಾಯ ದೃಷ್ಟಿಕೋನ (ಪಟ್ಟಿ – 06 + 07)		13–16 → ಹಸಿರು 8–12 → ಹಳದಿ 0–7 → ಕೆಂಪು	
9.	ಆಶಾ ಕಾರ್ಯಚಟುವಟಿಕೆ (ಪಟ್ಟಿ – 16)		10–12 → ಹಸಿರು 6–9 → ಹಳದಿ 0–5 → ಕೆಂಪು	
10.	ಅಡ್ಡ ಪರಿಣಾಮ ಅನುಭವಿಸಿದ ವರದಿ ಪಟ್ಟಿ – 14 ಮತ್ತು 15			
11.	ಸಮತೆ ಸೂಚ್ಯಂಕ $\left(\text{ಪಟ್ಟಿ} - \frac{04+06+08+10}{15+07+09+11}\right) \times 100$			

ಸಂಬಂಧಿತ ವಿಷಯಗಳು

ತಾಯಿ ಆರೋಗ್ಯ

1.

2.

3.

ಮಗುವಿನ ಆರೋಗ್ಯ

1.

2.

3.

ಗ್ರಾಮ ಆರೋಗ್ಯ ಮತ್ತು ನೈರ್ಮಲ್ಯ ಸಮಿತಿ

ರಾಜ್ಯ ಸಮುದಾಯ ಮೇಲ್ವಿಚಾರಣಾ ಸಲಹಾ ಸಮಿತಿ

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